

## **Health citizenship and “Closing the Gaps”: Maori and health policy**

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In 2000 New Zealand’s Labour Government announced a new health initiative in relation to the country’s Maori people. Called “Closing the Gaps”, this was intended to reduce the disparities between the health status of Maori and non-Maori. Health inequalities were not new, nor was this the first time they had been acknowledged. What was novel, however, was the politically contested nature of the policy. In order to understand this policy and the subsequent furore it caused, it is necessary to place it in the context of broader social policies in New Zealand as well as changing relationships between the dominant Pakeha (European) population and the tangata whenua — “the People of the Land”, the indigenous population of New Zealand, the Maori, who currently comprise almost 15 per cent of New Zealand’s four million citizens.

For Norway, Teemu Ryymin recognised four phases in the relationship between state efforts of health enhancement of indigenous people (the Sámi) and the politics of citizenship from the mid-nineteenth century to the late twentieth century.<sup>1</sup> The first phase, from the 1880s to the 1920s, saw governmental attempts to construct a politically and culturally homogenous citizenry, which meant that minorities had to change their culture to become full (and healthy) citizens. The second phase from the 1930s to the late 1950s saw the growth of the welfare state and the attempt by the government to ensure equal access to health services. The third phase from the early 1960s saw an acknowledgement of cultural diversity. The final phase, arising from movements for self-determination, emerged from the 1980s. In New Zealand too, health citizenship of its indigenous people has been influenced by broader political,

social and cultural movements, including changing ideas about the government's social responsibility and the changing status of Maori in New Zealand society. The four phases identified by Ryymin were played out in a broadly similar way in New Zealand in relation to Maori: the first phase (up to 1930) aimed at "Europeanisation" or "amalgamation", the second at "assimilation" (1930-60), and the third phase at "integration" (1960-80). The final phase, "self-determination", emerged from the late 1970s. The latter phase coincided with the "rolling back of the State" in welfare provision, with a targeted rather than universal approach, and also with the new understanding and heightened public discussion of the State's responsibility under the Treaty of Waitangi.

### **The four phases of health citizenship**

The first phase can be illustrated by an 1884 school textbook called *Health for the Maori: A Manual for Use in Native Schools*, which urged Maori to live in a European manner for the sake of their health.<sup>2</sup> The early twentieth century saw the foundation of a new Maori activist group, the Young Maori Party, which sought to reverse the population decline which had occurred since colonisation (from 100,000 in the mid-nineteenth century to 40,000 by the 1890s). When the New Zealand Department of Health was established in 1900, Maui Pomare, the first Maori to graduate in Western medicine and a member of the Party, was appointed Health Officer to the Maori; in his first annual report Pomare described Maori as "just [having] stepped out of Neolithic darkness into the blazing, dazzling light of civilisation".<sup>3</sup>

The second phase occurred under the first Labour Government (1935-49), which promoted universal welfare from the cradle to the grave; Maori were to be treated equally with other citizens in access to health care.<sup>4</sup> The assimilationist approach to

Maori health was encapsulated in a statement by Health Officer Dr Harold Turbott, who declared in 1938 that the aim of health policy relating to Maori was to turn them into “hardy, healthy, self-supporting, brown-skinned New Zealanders”.<sup>5</sup> The Labour Government’s adherence to assimilation can be seen in its housing policy of “pepper potting” — placing Maori families in predominantly Pakeha state house areas rather than keeping them apart.<sup>6</sup> The 1945 Maori Social and Economic Advancement Act was “designed to integrate Maori fully into the social and economic structure of the country”. The Department of Maori Affairs established both a Maori Welfare Division to operate through tribal committees and the Maori Women’s Welfare League, with the latter focusing upon promoting Maori health. The leaders of these organisations were to follow Maori tradition but in a way geared to modern conditions.<sup>7</sup>

These Maori-led organisations paved the way for a new official policy in the 1960s of “integration” as opposed to “assimilation”. A wide-ranging 1960 Department of Maori Affairs report (commonly referred to as the Hunn Report), written within the context of growing urbanization of the Maori people, signaled this new initiative. “Integration” was defined as the attempt “to combine (not fuse) the Maori and Pakeha elements to form one nation wherein Maori culture remains distinct”.<sup>8</sup> From 1962 Maori tohunga (healers), outlawed as part of the anti-quackery movement in the early twentieth century, were again sanctioned as health practitioners.<sup>9</sup>

Ironically, the new policy of integration coincided with the first systematic attempts to quantify disparities between Maori and non-Maori health status. Health researchers had taken a sporadic or occasional interest since the late nineteenth century, with the most detailed project being Dr Harold Turbott’s 1930s survey of Maori tuberculosis rates.<sup>10</sup> When Turbott became Director-General of Health in 1960, he heralded a forthcoming report on the disparity between Maori and European as a

first step towards “the enlistment of Maori interest and cooperation in the betterment of Maori health”.<sup>11</sup> *Maori-European Standards of Health* appeared in April 1960, pre-dating the Department of Maori Affairs report, and was quickly followed by *Maori Patients in Mental Hospitals* (1962), *Infant and Foetal Loss in New Zealand* (1964), *Diseases of the Ear, Nose and Throat in Maori Children* (1965), and *Maori Patients in Public Hospitals* (1965).

A generation later, Professor Eru Pomare, Maui’s grandson and the foremost Maori doctor of his time, was commissioned by the Forward Planning Committee of the Medical Research Council of New Zealand to lead a study of Maori standards of health from 1955 to 1975.<sup>12</sup> Pomare was keen to bring Maori health issues to the fore, even though some commentators felt the statistics showed Maori in a negative fashion. A second report, updating the figures to 1984, was published in 1988 and the third appeared posthumously in 1995, following Pomare’s untimely death.<sup>13</sup> All three reports formed a sound basis from which to discuss Maori health policy in the fourth phase of health citizenship.

“Integration” became “self-determination” from the 1970s as an increasingly urbanised and politicised Maori, influenced by the international civil rights movements, began to demand more agency in policymaking and implementation. In 1975 Matiu Rata, MP for Northern Maori, engineered the passage of the Treaty of Waitangi Act under which Maori complaints about breaches of the Treaty would be heard by a Tribunal. This Act has been described as “an enormously important milestone”. As historian Graeme Butterworth explained, “For the first time the Treaty was given not only statutory recognition but became a yardstick against which government legislation, policies and actions could be measured.”<sup>14</sup> The “principles of

the Treaty of Waitangi” were incorporated into much subsequent legislation, including health legislation.

### **The Treaty of Waitangi**

The Treaty of Waitangi was signed on 6 February 1840 between a representative of the British Crown and fifty Maori Chiefs of New Zealand. It ceded sovereignty to the British Crown (Article 1) in return for protection of lands, forests, fisheries and other property possessed by Maori, collectively or individually (Article 2). The Maori version included the word “taonga” (treasures) which could be, and subsequently was, interpreted to include health. Article 3 promised Maori “all the Rights and Privileges of British Subjects”.<sup>15</sup>

There was considerable confusion about the relevance of the Treaty to health over the next hundred years. New Zealand was not alone in this. A study on the history of aboriginal health in Canada identified similar levels of uncertainty relating to the rights to health care under various treaties signed in the nineteenth century.<sup>16</sup> In early twentieth-century New Zealand one Native Health Nurse reported that local Maori believed they were entitled to medical services under “a certain treaty”, but she could not verify it.<sup>17</sup> The Health Department’s medical secretary, Dr Joseph Frengley, researched the implications of the Treaty for health policy, and concluded that there was no obligation to provide free medical assistance other than for indigent Maori.<sup>18</sup> This mirrored attitudes towards medical care for non-Maori, whose needs were met by a government-sponsored charitable aid system, New Zealand’s equivalent to the English and Scottish poor law systems.<sup>19</sup>

The Health Department re-affirmed its interpretation of the Treaty in 1921, when it declared, “The Treaty of Waitangi, which is often quoted as implying some

obligation on Government to give free medical treatment to the Natives, is absolutely silent on the point, and simply conveys the full right and undisturbed possession of their lands to the Maoris.”<sup>20</sup> At the end of the 1920s the matter was raised again in the context of Maori inability to pay hospital fees. At a meeting between the Hospital Boards Association (HBA) and Prime Minister Joseph Ward (who had been New Zealand’s first Minister of Public Health from 1900 to 1906), the HBA chairman observed that Maori “seemed to have an idea in their heads that there was something in the Treaty of Waitangi which entitled them to free hospital treatment”. Ward told them that the government had no funds to finance their treatment but made no comment on the validity of the claims.<sup>21</sup>

In 1933 the Director-General of Health again argued that the Treaty did not include the right to free hospital treatment.<sup>22</sup> However, at least one external observer was not convinced. Professor Ivan Sutherland, an ethnologist, wrote in 1935 that all white New Zealanders should be ashamed of the current status of Maori health and, significantly, that the terms of the Treaty had not been honoured.<sup>23</sup> Sutherland’s concerns about Maori health coincided with those of the first Labour Government, which sought to promote equality for Maori in New Zealand society in all respects. Following the introduction of hospital and other health benefits under the 1938 Social Security Act, however, there was little further interest in the question of specific Maori entitlement for almost half a century.<sup>24</sup>

### **The Treaty and late twentieth-century health citizenship**

By the 1980s a view was emerging that the Treaty of Waitangi had direct relevance to Maori health. The catalyst for a change in perceptions was the 1975 Treaty of Waitangi Act, which afforded the Treaty greater status in law. However, the health

implications of the new legislation were not recognised until the following decade. In 1984 a special health hui (meeting) was seen as a milestone; the Director-General of Health and the Director of the Medical Research Council declared, “The recommendations of this hui, coupled with the Government’s increased commitment to honouring the principles of the Treaty of Waitanga and desire to develop a bicultural state sector are beginning to have an impact on the delivery of culturally sensitive [health] services”.<sup>25</sup> The following year the Board of Health’s Standing Committee on Maori Health recommended that the Treaty of Waitangi be regarded as a foundation for good health.<sup>26</sup> A decade later, the Public Health Commission’s Strategic Plan for Maori Health affirmed that, “Any discussion on Maori public health must begin with reference to the Treaty of Waitangi.”<sup>27</sup>

The new centrality of the Treaty to social policy arose largely as a result of Maori activism and heightened cultural awareness. The arguments that Maori were entitled to special consideration under the Treaty of Waitangi appeared to be accepted by the government and its departments and were incorporated into policy statements. Professor Mason Durie, a psychiatrist, widely respected Maori leader, and prolific writer on Maori health issues from the mid-1980s, was particularly outspoken.<sup>28</sup> He attributed health disparities to previous failures to implement the Treaty, pointing out that the government had not achieved the central goal of the Treaty: to protect Maori against the effects of colonisation.<sup>29</sup> He claimed that separation from the land had itself been a prescription for illness, citing recent health statistics to demonstrate that Article 2 of the Treaty (protection) had not been honoured. Others also stressed the importance of the Treaty.<sup>30</sup> Durie stated definitively that “good health is clearly an objective of the Treaty”.<sup>31</sup> Honouring Article 2 involved the principles of decision-making and self-determination in health, and the government moved towards

devolving health care provision to local iwi or communities. This could also be seen as a cutting-back of centralist services, and hence a policy suited to a government intent on dismantling the welfare state.<sup>32</sup>

Article 3 of the Treaty, which guaranteed Maori the rights and privileges of British subjects, was also invoked as integral to health policy. Durie pointed out, however, that “rights” did not just apply to “service delivery”, and he believed it was a mistake to assume “the application of one law for all individuals can best be achieved by adopting a single set of standards, regardless of culture, class or gender.”<sup>33</sup> Equality of access to health services was not enough, as it had been under the first Labour Government; equality was now interpreted as a demand for equality of health status. Whilst Maori health had improved steadily over the years, in all indicators of health status, they still lagged behind non-Maori.<sup>34</sup> Dr Paparangi Reid, a Maori public health specialist who is currently Maori Dean (Tumuaki) at the University of Auckland’s Faculty of Health and Medical Sciences, critiqued the government’s Maori health policy, pointing out while that Maori had assumed “equity” meant equity of outcome, the government talked only of equity in accessing health services. In her opinion the Crown had the “most immoral relationship with us as tangata whenua”.<sup>35</sup> Health citizenship now meant equal access to health status not health services, something which required targeted as opposed to universalist services, which again suited a government intent on the dismantling of the universalist welfare state.

### **“Closing the Gaps” and “Privileged Citizens”?**

As noted earlier, there was nothing new in the concept of reducing disparities between Maori and non-Maori health. Even the terminology was borrowed from previous



generations. In 1961, for instance, the Hunn Report noted that the amelioration of Maori health dated from the 1890s, “but old ways persist enough to impede all efforts of the Health Department and Maori Affairs Department to close the statistical gap”.<sup>36</sup> When the Medical Research Council of New Zealand investigated the country’s health statistics in 1969 it stated that,

Theoretically there should not be any disparity in mortality between the two races because all legislation, health and hygienic regulations and social welfare and medical care, are available to Maori and European alike (...). The explanation lies in a handicap, which all developing nations have to overcome, in their attitude to health and hygiene and in overall living standards.<sup>37</sup>

Politicians were slow to react to these findings. Aussie Malcolm, the National Government’s Health Minister, freely admitted in 1983 that “we have always failed to bridge the gap”,<sup>38</sup> but his government was ousted in a snap election in July 1984. The incoming Labour Government held a Maori economic development conference, which was heralded in a joint report of the Department of Maori Affairs, the Board of Maori Affairs and the Maori Trust Office as a new challenge for Maoridom, marking the start of a decade of challenge to “close the social and economic gaps that have existed between Maori and Pakeha since the Treaty of Waitangi”. As ever, housing, unemployment, health and educational underachievement were regarded as the “hard issues”.<sup>39</sup> There was little real change, however, during the fourth Labour Government’s tenure (1984-90), as it concentrated on economic reforms. Nor did the National Party tackle the issue during its term of office (1990-9), when it concentrated on restructuring the health system, replacing the Health Department with a new

Ministry of Health, introducing population-based funding, and devolving more responsibility to regional authorities.

During its short-lived tenure (1993-95) the Public Health Commission acknowledged there was a “special need to improve the health of Maori”, and the second of its six goals was “to improve Maori health status so that in future Maori will have the opportunity to enjoy at least the same level of health as non-Maori”.<sup>40</sup> To this end the Commission published a strategic plan.<sup>41</sup> Yet the disbanding of the Public Health Commission did open the way for greater self-determination in Maori health as health services were increasingly devolved. In 1997 the National Government created four Maori Development Commissions to oversee and implement policy relating to education, the labour market, economic business development, and health. The Maori Health Commission was intended, in the words of Maori Affairs Minister Tau Henare, “to do whatever it takes to reduce the disparities in health which exist between Maori and non-Maori”. The Maori Health Commission chair, Wayne McLean, hailed its first report, issued in June 1998, as a milestone because this was the first body “to improve Maori health, controlled by Maori for Maori”. Other contributors to the report were equally optimistic. Henare saw this as a grassroots solution to combat inequality in health and promised there was the political will within Cabinet to “make Maori aspirations a reality”. Annette Dixon, Deputy Director General of Health Strategic Planning and Policy, argued that the reforms provided new opportunities for Maori health gains, and reminded readers of the priority given in the 1994/5 policy guidelines to “close the unacceptable gap” and the commitment to be responsive to the tangata whenua in line with the principles of the Treaty of Waitangi.<sup>42</sup>

A year after Labour returned to office in 1999 it set up a “Closing the Gaps” cabinet committee to tackle the perennial problem areas of Maori education, employment and health. To some extent this was a continuation of past initiatives but now caused an unprecedented public furor. Approximately half the policy strands were geared specifically towards Maori and Pacific Islander needs, with the remainder targeted on what Labour would later term the “general disadvantaged”.<sup>43</sup> While a *New Zealand Herald* columnist noted that in some areas the gaps had been “seamlessly expanded to cover the whole of the rich-poor divide”,<sup>44</sup> there was considerable public and political opposition to “Closing the Gaps” on the grounds it was biased in favour of Maori and Pacific Islanders to the exclusion of other low-income groups. The spark which ignited public debate was a speech by Maori activist and Labour MP Tariana Turia, who declared that Maori tribes had suffered a “holocaust” as a result of colonization.<sup>45</sup> Prime Minister Helen Clark was concerned that Turia’s views would erode support for the policy (and the government) from middle (white) New Zealand.<sup>46</sup> Treaty of Waitangi Negotiations Minister Margaret Wilson denied that the “Closing the Gaps” policy would create apartheid in the health system.<sup>47</sup> However, Race Relations Conciliator Dr Rajen Prasad warned that the process would be divisive. National’s health spokesman Wyatt Creech applauded Prasad’s comments on the divisiveness of Labour’s policy as a “sobering and courageous warning in a ‘politically correct’ world”.<sup>48</sup> By January 2001 “Closing the Gaps” had disappeared from the political lexicon and been replaced by the phrase “social equity”, with equivalent changes in the committee name.<sup>49</sup> The rhetoric around “Closing the Gaps” had been considered too politically loaded.

While the phrase “Closing the Gaps” was dropped as potentially racially-divisive, the concept underlying the policy was still in place and became subject to a vehement

attack on Labour policies by the Leader of the Opposition, Dr Don Brash, in 2004.<sup>50</sup> He spoke of the “dangerous drift towards racial separatism in New Zealand (...) We are one country with many peoples, not simply a society of Pakeha and Maori where the minority has a birthright to the upper hand.” He asked whether New Zealand was to be “a modern democratic society, embodying the essential notion of one rule for all in a single nation state? Or is it the racially divided nation, with two sets of laws, and two standards of citizenship (...)?” Further, he argued, “In both education and healthcare, government funding is now influenced not just by need — as it should be — but also by the ethnicity of the recipient.” The speech dramatically raised National’s popularity in the polls, although this was short-lived since Brash was unpopular in other ways.

However, targeting health inequalities has not only been defined by some Pakeha as privileging Maori and ignoring other disadvantaged groups, but also by some Maori as discriminatory and stigmatizing. Some earlier attempts at targeting had also been resented as racist, either at the time or in hindsight. In the 1920s Maori children were routinely inoculated against typhoid with the blessing of Maori leaders, who acknowledged the impact of the disease on communities which lacked the resources to improve sanitary conditions. In 1913, for example, the prominent Maori MP Apirana Ngata spoke out in favour of compulsory inoculation, if the medical profession believed this would act as a preventative.<sup>51</sup> While in the 1920s Maori still appeared enthusiastic about immunization,<sup>52</sup> by the 1940s some Maori were refusing to allow their children to be vaccinated against typhoid on the grounds that white children were not required to be vaccinated.<sup>53</sup> In the 1930s, following research which demonstrated that Maori tuberculosis rates were at least ten times greater than those for non-Maori, Ngata called for the introduction of BCG vaccination for Maori. The

request was refused at that time, but Maori were classed as a priority group when vaccination began in the late 1940s.<sup>54</sup> One long-term consequence was that the Health Department maintained universal BCG vaccination of school children in the 1960s and 1970s, long after Maori had been identified as a particular at-risk group and TB had ceased to be a problem in the general population; they did so because of the fear that targeting Maori would be seen as racist and stigmatizing Maori as harbourers of the disease.<sup>55</sup> There were similar concerns with the Hepatitis B vaccine in the 1980s. On the one hand there were moves to target Maori children as having much higher rates than non-Maori, on the other some Maori claimed Maori were being experimented upon for the new vaccine.<sup>56</sup> There were also problems with targeted programmes to treat sexually transmitted diseases, since these could be interpreted as stigmatizing Maori as immoral, given the personal responsibility attached to those diseases.<sup>57</sup>

The concept of “Closing the Gaps” has been a part of New Zealand health strategy for many years. By 2000, however, it had become politicised and polarised as never before. Maori activists of the late twentieth century demanded not equality of access to health care, but equality of health status; health citizenship meant equal health status. This required affirmative and targeted public health programmes. To some extent this fitted the late twentieth-century political agenda of moving away from universalist to targeted welfare. Mason Durie saw positive benefits for Maori, despite a decrease in welfare funding, as they were given responsibility for their own health management.<sup>58</sup> However, others saw it as divisive, and as positively discriminating in favour of Maori. They argued that Maori were now privileged citizens. Some Maori saw targeted programmes as discriminatory and stigmatizing, as with it went the attribution of blame and a heightened perception of being “diseased”

by virtue of being Maori. Strategies for achieving “health citizenship” and the meanings attached to it changed over the years; yet for all that, health inequalities persisted.

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<sup>1</sup> Ryymin, Teemu. “Health Policies, Indigenous People and Citizenship on the Arctic and Pacific Rim.” Unpublished Research Proposal, University of Bergen, Bergen 2008.

<sup>2</sup> Pope, James. *Health for the Maori: A Manual for Use in Native Schools*. Government Printer, Wellington 1884. The author was the Organising Inspector for Maori Schools.

<sup>3</sup> “Report of Dr Pomare, Health Officer to the Maoris.” *Appendices to the Journals of the House of Representatives (AJHR)* H-31, Wellington 1904: 56.

<sup>4</sup> See, for example, Tennant, Margaret. *Children’s Health, The Nation’s Wealth: A History of Children’s Health Camps*. Bridget Williams Books, Wellington 1994: 130.

<sup>5</sup> Turbott, H.B. “Health and Social Welfare.” In Sutherland, I.L.G. (ed.). *The Maori People Today: A General Survey. Issued under the auspices of the New Zealand Institute of International Affairs and the New Zealand Council for Educational Research*. Whitcombe & Tombs and Oxford University Press, Auckland and London 1940: 268.

<sup>6</sup> Ferguson, Gael. *Building the New Zealand Dream*. Dunmore Press & Historical Branch Department of Internal Affairs, Palmerston North 1994: 168, 204.

<sup>7</sup> Harris, Aroha. “Maori and ‘the Maori Affairs’.” In Dalley, Bronwyn and Margaret Tennant (eds). *Past Judgement: Social Policy in New Zealand History*. Otago University Press, Otago 2004: 192, 194.

<sup>8</sup> Dunstall, Graeme. “The Social Pattern.” In Rice, G.W. (ed.). *The Oxford History of New Zealand*. 2<sup>nd</sup> edn, Oxford University Press, Auckland 1992: 478.

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<sup>9</sup> See Dow, Derek A. “‘Pruned of its dangers’: The Tohunga Suppression Act 1907.” *Health and History* 3/1 (2001): 41-64.

<sup>10</sup> See Dow, D., “Driving Their Own Health Canoe: Maori and Health Research.” In Dalley and Tennant 2004: 91-107.

<sup>11</sup> *AJHR* H-31, 1960: 10-11.

<sup>12</sup> Pomare, E.W.H. *Maori Standards of Health: A Study of the 20 Year Period 1955-75: A Report prepared for the Medical Research Council of New Zealand*. The Health Research Council, Wellington 1980.

<sup>13</sup> Pomare, E.W.H. and G. M. de Boer. *Hauora: Maori Standards of Health: A Study of the Years 1970-1984: Department of Health Special Report Series Number 78*. Wellington 1988; Pomare, E.W.H., V. Keefe-Ormsby, C. Ormsby, N. Pearce, P. Reid, B. Robson and N. Watane-Haydon. *Hauora: Maori Standards of Health III: A Study of the Years 1970-1991*. Wellington 1995.

<sup>14</sup> Butterworth, G.V. and H.R. Young. *Maori Affairs*. Iwi Transition Agency, GP Books, Wellington 1990: 110.

<sup>15</sup> For a discussion of the different interpretations of the Treaty, see also Orange, Claudia. *The Treaty of Waitangi*. Allen & Unwin, Port Nicholson Press, Wellington 1987.

<sup>16</sup> Waldram, J.B., D.A. Herring and T.K. Young. *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives*. University of Toronto Press, Toronto 1995: 141, 146, 149, 228-31.

<sup>17</sup> Native Health Nurse to District Health Officer, 28 October 1913, in “Native Medical Aid: Johnsonville.” H1 160/47 17665, Archives New Zealand, Wellington.

<sup>18</sup> Health Department. “Annual Report.” *AJHR* H-31, 1913: 2-3.

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<sup>19</sup> Tennant, Margaret. *Paupers and Providers: Charitable Aid in New Zealand*. Allen & Unwin and Historical Branch Department of Internal Affairs, Wellington 1989.

<sup>20</sup> "Patients' Payments." *The New Zealand Journal of Health and Hospitals* 4/12 (December 1921): 348-9. For a discussion of Civil List payments see Dow, Derek A. *Maori Health & Government Policy 1840-1940*. Victoria University Press and Historical Branch Department of Internal Affairs, Wellington 1999.

<sup>21</sup> *Dominion*, 6 September 1929.

<sup>22</sup> Director-General of Health to Secretary of Waitaki Hospital Board, 5 July 1933, in "Hospital Boards: General: Maori Patients in Hospitals 1922-35." H1 54/24 B.19, Archives New Zealand, Wellington.

<sup>23</sup> Sutherland, I. L.G. *The Maori Situation*. Tombs, Wellington 1935: 116-19.

<sup>24</sup> For a fuller account of the discussions about hospital funding see Dow 1995: 161-72

<sup>25</sup> Salmond, George and J.V. Hodge. "Foreword." In Pomare and de Boer 1988: 8.

<sup>26</sup> Durie, M.H. "The Treaty of Waitangi and Health Care." *New Zealand Medical Journal* 102 (1989): 203; Durie, M.H. *Whaiora: Maori Health Development*. Oxford University Press, Auckland 1998: 81.

<sup>27</sup> Public Health Commission. *He Matariki: A Strategic Plan for Maori Public Health. He Kaupapa Whaingā Roa Mo Te Hauora Tūmatanui Maori. The Public Health Commission's Advice to the Minister of Health 1994-1995*. Public Health Commission, Wellington 1995: 13, 34.

<sup>28</sup> Durie 1998: vii, 3.

<sup>29</sup> Durie, M.H. "The Treaty of Waitangi – Perspectives on Social Policy." In Kawharu, I.H. (ed.). *Waitangi: Maori & Pakeha Perspectives of the Treaty of Waitangi*. Oxford University Press, Auckland 1989: 285, 287.



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- <sup>30</sup> See, for example, Smith, Linda Tuhiwai. *Decolonizing Methodologies: Research and Indigenous Peoples*. Zed Books and University of Otago Press, New York and Dunedin 1998.
- <sup>31</sup> Durie 1989: 205.
- <sup>32</sup> Rice, Geoffrey. "A Revolution in Social Policy, 1981-1991." In Rice 1992: 482-497.
- <sup>33</sup> Durie 1989: 288.
- <sup>34</sup> Durie 1998: 55, 83, 88.
- <sup>35</sup> Brown A. (ed.). *Mana Wahine: Women Who Show the Way*. Auckland, 1994: 58-61.
- <sup>36</sup> Hunn, J. K. *Report on the Department of Maori Affairs with Statistical Supplement (24 August 1960)*. Wellington 1961: 20.
- <sup>37</sup> Medical Research Council of New Zealand. *Adequacy of Medical Statistics in New Zealand: Report of an Ad Hoc Committee ... presented to Council in November 1969*. Wellington 1969: 26.
- <sup>38</sup> 'Nurses Must Play Their Part in Shaping the Future' (Address by Aussie Malcolm to the New Zealand Nurses' Association Conference), *New Zealand Nursing Journal* 77/5 (May 1984): 13-16.
- <sup>39</sup> *AJHR* E-13, 1985: 3.
- <sup>40</sup> Public Health Commission. *Our Health, Our Future: Hauora Pakiri, Koiora Roa: The State of the Public Health in New Zealand*. Wellington 1994: 13, 186.
- <sup>41</sup> New Zealand: Public Health Commission. *He Matariki: A Strategic Plan for Maori Public Health. He Kaupapa Whaingā Roa Mo Te Hauora Tūmatanui Maori. The Public Health Commission's Advice to the Minister of Health 1994-1995*. Wellington 1995.
- <sup>42</sup> New Zealand: Maori Health Commission. *Tihei Mauri Ora! / The Maori Health Commission*. Wellington 1998: 4-6, 84.

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<sup>43</sup> Pacific Islanders had come to New Zealand increasingly from the 1960s in search of jobs; with the economic downturn in the 1970s they, like Maori, became the underclass, and were also affected by the cutting back of welfare from the 1980s. See Boyd, Mary. "New Zealand and the other Pacific Islands." In Sinclair, Keith (ed.). *Oxford Illustrated History of New Zealand*. Oxford University Press, Auckland 1996: 295-322.

<sup>44</sup> *New Zealand Herald*, 16 June 2000.

<sup>45</sup> *New Zealand Herald*, 30 August 2000.

<sup>46</sup> *New Zealand Herald*, 30 August 2000; *New Zealand Herald*, 31 August 2000;

Sandra Lee also used the term to describe colonisation at a national hui on child abuse: *New Zealand Herald*, 6 November 2000.

<sup>47</sup> *Sunday Star-Times*, 17 September 2000.

<sup>48</sup> *New Zealand Herald*, 26 October 2000.

<sup>49</sup> *Sunday Star-Times* 10 December 2000; For a summary of events see *Sunday Star-Times*, 17 September 2000, 10 December 2000; "Next Generation to See Gaps Close." *New Zealand Herald*, 23 September 2000; "Closing the Gaps Divisive, Says Race Conciliator." *New Zealand Herald*, 26 October 2000; "Turia Supports Clark in Dumping 'gaps' Phrase." *New Zealand Herald*, 12 December 2000; "Closing the Gaps." *New Zealand Herald*, 20 December 2000; Small, V. "Tarnished GAPs Goes – Social Equity Is In." *New Zealand Herald*, 10 February 2001.

<sup>50</sup> "Don Brash's Orewa Speech, 27 January 2004." Scoop Media Group: <http://www.scoop.co.nz/stories/PA0401/S00220.htm>.

<sup>51</sup> *New Zealand Parliamentary Debates*, 26 September 1913, 165: 262.

<sup>52</sup> Health Department. "Annual Report." *AJHR* H-31, 1922: 5.

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<sup>53</sup> Day, Alison. "Child Immunisation: Reactions and Responses to New Zealand Government Policy 1920-1990." PhD thesis, The University of Auckland 2008.

<sup>54</sup> Dow 1995: 195-196.

<sup>55</sup> Dunsford, Deborah. "Seeking the Prize of Eradication: A Social History of Tuberculosis in New Zealand from World War Two to the 1970s." PhD thesis, The University of Auckland 2008.

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